STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G116	A. BUILDING 00 B. WING	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	1734 JEFFREY DR LOWELL, IN 46356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 5/1, 5/2, 5/3, 5/9, 5/10 and 5/16/13. Facility Number: 00653 Provider Number: 15G116 AIMS Number: 100234070 Surveyors: Paula Chika, QIDP-TC Christine Colon, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed May 24, 2013 by Dotty Walton, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed to maintain an accurate accounting system for 1 of 3 sampled clients (client #3), for whom the facility managed their personal funds' accounts. Findings include: A review of the facility's records was conducted at the group home on 5/1/13 at 6:45 P.M. A review of clients #3's personal petty cash financial record indicated the following: Client #3's personal financial accounting ledger dated 4/26/13 indicated he should have a balance of $12.95. Direct Support Professional #1 (DSP) reviewed the currency in client #3's petty cash pouch. There was no money in client #3's personal petty cash funds pouch to review. An interview with DSP #1 was conducted on 5/2/13 at 10:30 A.M. DSP #1 indicated each client's ledger entry balance and the currency amount should always match. DSP #1 further indicated there was no money to count.	W000140	Client #3 was in possession of the $12.95; however, staff did not accurately document this on the budget sheet. Budget sheet was reconciled to reflect the correct documentation. The Service Coordinator will re-audit all client budget sheet and funds at the home to ensure no further errors were made by 6/15/13. The process for safely maintaining client funds is being revised. Once this is completed all staff will be retrained on the process including modeling and return demonstrations of the needed skills. Service Coordinators will ensure the financials are completed biweekly and the Behavioral Health Director will ensure that a random audit of client financials is completed each month, and then will fade to quarterly audits once proficiency in the new system is established.	06/15/2013

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	9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 3 sampled clients (#2) and for 2 additional clients (#4 and #5), the facility failed to implement its policy and procedures to prevent neglect of clients in regard to client to client aggression where there was a pattern of 5 of 5 incidents reviewed. The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to the client to client abuse/aggression, injuries of unknown source, elopement/neglect and an allegation of possible client to client sexual abuse. The facility also failed to implement its policy and procedures to ensure an allegation of possible sexual abuse was reported to state officials. Findings include: 1. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following: -1/11/13 [Client #4] began yelling at	W000149	An IDT meeting was held to investigate the incidents regarding clients #2 and #4 on 5/13/13. No abuse, neglect or exploitation was suspected during these incidents. Client # 5 will have an IDT by 6/10/13 to rule out abuse, neglect or exploitation modifications to his plan and recommendations will follow this meeting. Corrective actions of the Behavior Plans for clients #2 and #4 have been revised to indicate that both clients are to be monitored for the remainder of the day following any aggression. An IDT meeting will occur within 24 hours of any episode of client on client aggression to determine if abuse, neglect, or exploitation occurred. Protective measures will be put into place to ensure the safety of all clients following aggression. To ensure future compliance, posters explaining client rights and reporting requirements were distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally, all staff will be trained on reporting and investigation requirements for Abuse, Neglect, and Exploitation at least annually unless changes occur or need requires this to be	06/10/2013

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	[client #2] saying that [client #2] could not tell him what to do. [Client #2] then pushed [client #4] which made [client #4] fall backwards onto his buttocks." The I/A indicated client #4 was not injured. The I/A indicated "...Bx (behavior) Plan in place to address aggression. Plan appears to overall be effective incidents within normal range (sic)...." -10/21/12 "[Client #2] was talking with client. [Client #4] said 'shut up' to [client #2]. [Client #2] then hit him (client #4) and started yelling. Staff separated, redirected and told him that is not appropriate." The 10/12/12 I/A indicated client #4 was not injured. The I/A report indicated the clients were separated and "...monitored for further aggression. None occurred. Behavior plans followed...." -10/20/12 "[Client #2] was singing children's songs. [Client #4] got irritated and told [client #2] to shut up while using profanity and smacked [client #2] on his back." The I/A report indicated client #2 was not injured. The 10/20/12 I/A indicated the clients were separated and monitored for further aggression. The I/A report indicated "Behavior Plans followed." -10/12/12 "Both clients (clients #2 and		done more frequently. To ensure that Service Coordinators are trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin, the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral Health Director will review progress notes regularly. To ensure future compliance, The Service Coordinator will visit the clients once a week at home and once a week at the day services program for two months to ensure behavior plans are followed and recommendations put in place	

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	#4) were agitated on arrival (to work) & (and) staff directed them to stay separate & calm down. [Client #4] walked over into the area & [client #2] approached him saying why you have to be like that & [client #4] went after him (client #2) and fight insued (sic). No punching more arm slapping." The I/A indicated clients #2 and #4 were not injured. The I/S report indicated client #2 and #4's behavior plans addressed aggression. -9/28/12 '[Client #4] hit [client #2] on his (R) (right) shoulder." The I/A report indicated client #4 was redirected. The I/A report indicated client #2 was not injured. The above mentioned I/A reports of client to client aggression/abuse indicated the facility did not conduct an investigation in regard to the incidents of aggression/abuse. The above mentioned incidents of client to client aggression/abuse also indicated the facility failed to put corrective measures in place which addressed the targeted incidents of aggression between the clients. Client #2's record was reviewed on 5/2/13 at 3:39 PM. Client #2's 3/13 Behavior Plan indicated client #2 demonstrated verbal aggression which was defined as		are carried out. 6/14/13In addition to the submitted plan, a system for identifying and determining cause/effect and preventative approaches to incidents of client-to-client aggression will be developed by 6/15/13. Client to client aggression will be reported to the administrator and BDDS as applicable. If needed, an IDT meeting will be held to discuss modifications to the milieu, behavior plans, staff assignments, additional training, or disciplinary measures, or other issues specifically relevant to the client/s. Once developed, staff will be trained on this system. The system will be monitored by the Behavioral Health Director or designee who will review incident reports involving client to client aggression to ensure system compliance. Changes will be made if necessary to the system as needed to assure the effectiveness of the methodology. 6/21/13 While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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	"Name Calling, Swearing, or Yelling." The 3/13 plan also indicated client #2 demonstrated physical aggression which was defined as "[Client #2] will throw objects when angry with the potential of hitting others, or striking other with an open or closed hand." Client #2's 3/13 behavior plan indicated client #2 should be separated from others when he became aggressive. The behavior plan indicated staff was to tell client #2 "...his actions are inappropriate and that talking is a much more effective way of dealing with her (sic) problems...." The plan also indicated facility staff were to encourage the client to participate in deep breathing relaxation exercises. The plan indicated if the client did not calm down and continued aggression, the least restrictive behavioral intervention techniques could be used. Client #2's 3/11/13 Individual Support Plan (ISP) and/or 3/13 behavior plan indicated the client's interdisciplinary team did not meet to address the identified pattern of aggression between clients #2 and #4. Client #4's record was reviewed on 5/3/13 at 2:25 PM. Client #4's 3/13 Positive Behavioral Supports indicated client #4 demonstrated verbal aggression defined as "includes but not limited to verbal threats,			

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	to staff or peers involving any kind of harm, the use of derogatory terminology and increased volume of speech or yelling." The 3/13 behavior plan also indicated client #4 demonstrated physical aggression defined as "includes but not limited to hitting, kicking, grabbing, shoving or the use of an object as a weapon to attempt to intentionally cause harm to others." Client #4's behavior plan indicated others should be removed from the area when client #4 demonstrated physical aggression. The plan indicated staff was to tell client #4 "...his actions are inappropriate and that talking is a much more effective way of dealing with her (sic) problems...." The plan also indicated facility staff were to encourage the client to participate in deep breathing relaxation exercises. The plan indicated if the client did not calm down and continued aggression, the least restrictive behavioral intervention techniques could be used. Client #4's 3/5/13 ISP and/or 3/13 Positive Behavioral Supports plan indicated the client's interdisciplinary team (IDT) did not meet to address the identified pattern of aggression between clients #2 and #4. Interview with administrative staff #1 and Service Coordinator (SC) #1 on 5/3/13 at			

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	3:10 PM indicated clients #2 and #4 demonstrated physical aggression. Administrative staff #1 indicated most of the incidents between clients #2 and #4 occurred at the day service program. SC #1 indicated the day service program would conduct the investigations if they occurred at the day program. SC #1 indicated she (SC #1), administrative staff and/or the nurse would conduct the investigations if they occurred at the group home. Administrative staff #1 stated they would "meet as a group afterwards to evaluate if one is an abuser or feel he is being abused." Administrative staff #1 stated "No, we did not follow our policy." SC #1 indicated the clients' IDTs did not meet to address the identified pattern of aggression between the two clients. The facility's policy and procedures were reviewed on 5/2/13 at 11:59 AM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...I. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations if abuse, neglect or exploitation of our clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents. III. All			

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	allegations of abuse, neglect, humiliation or exploitation will be investigated per the Arc Northwest Indiana's investigation process, while protecting the individual...." 2. The facility's policy and procedures were reviewed on 5/2/13 at 11:59 AM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...I. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations if abuse, neglect or exploitation of our clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per the Arc Northwest Indiana's investigation process, while protecting the individual...." 1. The facility failed to report an allegation of possible sexual abuse and an incident of client to client abuse immediately to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC			

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	12-10-3 for clients #2, #4 and #5. Please see W153. 2. The facility failed to conduct thorough investigations in regard to client to client aggression, allegations of abuse, injuries of unknown source and/or incidents of neglect/elopement for clients #2, #4 and #5. Please W154. 3. The facility failed to put corrective measures in place in regard to the identified patterns of aggression for clients #2 and #4. Please see W157. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, interview and record review for 2 of 13 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to report an allegation of possible sexual abuse and an incident of client to client abuse immediately to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for clients #2, #4 and #5. Findings include: 1. The facility's reportable incident reports, Incident/Accident (I/A) Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's 5/24/12 I/A indicated "[Client #4] reported to staff [female client] has been touching him inappropriately on van." The facility's reportable incident reports reviewed from 5/12 to 5/13 indicated the facility did not report the 5/24/12	W000153	An IDT meeting was held to investigate the incidents regarding clients #2 and #4 on 5/13/13. No abuse, neglect or exploitation was suspected during these incidents. Client # 5 will have an IDT by 6/10/13 to rule out abuse, neglect or exploitation, modifications to his plan and recommendations will follow this meeting.. Corrective actions of the Behavior Plans for clients #2 and #4 have been revised to indicate that both clients are to be monitored for the remainder of the day following any aggression. An IDT meeting will occur within 24 hours of any episode of client on client aggression to determine if abuse, neglect, or exploitation occurred. Protective measures will be put into place to ensure the safety of all clients following aggression. To ensure future compliance, posters explaining client rights and reporting requirements were distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally all staff will be trained on reporting and investigation requirements for	06/10/2013

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	allegation of possible sexual abuse to BDDS or APS. Interview with administrative staff #1 on 5/3/13 at 3:10 PM indicated he did not locate a BDDS reportable incident report for 5/24/12 incident with client #4.		abuse, neglect, and exploitation at least annually unless changes occur or need requires this to be done more frequently. To ensure that Service Coordinators are trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin, the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral Health Director will review progress notes regularly. To ensure future compliance, The Service Coordinator will visit the clients once a week at home and once a week at the day services program	

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	2. A facility owned day program		for two months to ensure behavior plans are followed and recommendations put in place are carried out. 6/14/13In addition to the submitted plan, a system for identifying and determining cause/effect and preventative approaches to incidents of client-to-client aggression will be developed by 6/15/13. Client to client aggression will be reported to the administrator and BDDS as applicable. If needed, an IDT meeting will be held to discuss modifications to the milieu, behavior plans, staff assignments, additional training, or disciplinary measures, or other issues specifically relevant to the client/s. Once developed, staff will be trained on this system. The system will be monitored by the Behavioral Health Director or designee who will review incident reports involving client to client aggression to ensure system compliance. Changes will be made if necessary to the system as needed to assure the effectiveness of the methodology. 6/21/13 While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation was conducted on 5/3/13 from 10:00 A.M. until 11:05 A.M. At 10:10 A.M., client #5 was seated at a work table. Client #2 walked to the work table and stated, to this surveyor "Did you hear what I did? I pulled out a pocket knife, and showed it." Client #2 then pointed to client #5 and began saying "He thinks he's tough, he don't know how to fight, he ain't tough." Client #5 then said "Yeah he pulled out a knife, he's weak, he ain't tough." A review of the facility's records was conducted at the facility's administrative office on 5/3/13 at 12:05 P.M. Review of the facility's internal Incident/Accident reports indicated the following: -Incident report dated 5/1/13: "The clients told me that the bus driver wanted to talk to staff. He said that [client #2] had pulled out a 2 inch knife during the trip he told the driver he 'maybe' won't do it again. [Client #2] came outside to the van and was smiling and looking proud of himself, claiming he didn't do anything. When staff asked him for the knife, he stated it was his, he didn't steal it and didn't want it to be taken away...The SC (Service Coordinator) was called, she instructed to ask him for the knife and leave him alone otherwise. He was willing to bargain for it by midafternoon			

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	15G116	A. BUILDING 00 B. WING	05/16/2013

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	(keep it at home, don't take it to workshop) but didn't give it to staff till late in the evening. He wrapped it heavily in paper and tape and wrote his name. Staff unwrapped it to verify it really was a knife. It was a folding knife with a 2 inch blade and serrated edge. It looks easily concealable." No documentation was submitted for review to indicate the facility immediately reported the incident to the administrator and other officials (BDDS/APS). An interview with the Service (SC) was conducted at the facility's administrative office on 5/3/13 at 12:15 P.M. The SC indicated there was no evidence available for review to indicate this incident was reported immediately to the administrator or to the Bureau of Developmental Disabilities Services (BDDS). 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, interview and record review for 11 of 13 allegations of abuse, client to client abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to client to client aggression, allegations of abuse, injuries of unknown source and/or incidents of neglect/elopement for clients #2, #4 and #5. Findings include: 1. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's 3/12/13 reportable incident report indicated "Staff informed workshop manager at 12:20 pm that she could not find [client #2]. Staff paged [client #2] to the front office and had all staff search their areas within the building. Staff along with workshop manager left in their vehicles to search the neighborhood while center staff continued to look on site. Emergency services were called @ (at) 12:43 and arrived @ 12:55 to obtain a picture stating they would return. After speaking with emergency	W000154	An IDT meeting was held to investigate the incidents regarding to clients #2 and #4 5/13/13 no abuse, neglect or exploitation was suspected during these incidents. Client # 5 will have an IDT by 6/10/13 to rule out abuse, neglect or exploitation modifications to his plan and recommendations will follow this meeting. Corrective actions of the Behavior Plans for clients #2 and #4 have been revised to indicate that both clients are to be monitored for the remainder of the day following any aggression. An IDT meeting will occur within 24 hours of any episode of client on client aggression to determine if abuse, neglect, or exploitation occurred. Protective measures will be put into place to ensure the safety of all clients following aggression. To ensure future compliance, posters explaining client rights and reporting requirements were distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally all staff will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation at least annually unless changes occur or need requires this to be	06/10/2013

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	services, Facility Manager joined in a vehicle search. Staff in vehicles kept in contact via cell phones along with maintaining contact with center. At 1:23 pm, Facility Manager stated she had a visual on [client #2] and was at the Jeffery Group home in Lowell. She asked [client #2] if he wanted to come back in her vehicle to return to the center. [Client #2] took off a second time and entered the [name of restaurant] stating he wanted to go to the restroom when he came out he immediately went out the side door and headed East again. The [name of town] emergency made contact with surrounding communities and @ 1:30 the County sheriff and (sic) arrived to assist the Facility Manager. After emergency personnel spoke with [client #2] he willingly got in her vehicle and was transported back to the center...." The facility's 3/12/13 reportable incident report indicated client #4 was seen eating lunch at 12:05 PM, and had a one staff to 10 client ratio. The 3/12/13 reportable incident report did not indicate any additional information and/or documentation an investigation had been conducted. Interview with administrative staff #1 on 5/3/13 at 3:10 PM indicated the incident occurred at the facility owned day service program. Administrative staff #1		done more frequently. To ensure that Service Coordinators are trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin, the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral Health Director will review progress notes regularly. To ensure future compliance, The Service Coordinator will visit the clients once a week at home and once a week at the day services program for two months to ensure behavior plans are followed and recommendations put in place	

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	indicated the facility did not conduct an investigation in regard to the 3/12/13 elopement incident. 2. The facility's reportable incident reports, internal Incident/Accident Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following: -1/11/13 [Client #4] began yelling at [client #2] saying that [client #2] could not tell him what to do. [Client #2] then pushed [client #4] which made [client #4] fall backwards onto his buttocks." The I/A indicated client #4 was not injured. -10/21/12 "[Client #2] was talking with client. [Client #4] said 'shut up' to [client #2]. [Client #2] then hit him (client #4) and started yelling. Staff separated, redirected and told him that is not appropriate." The 10/12/12 I/A indicated client #4 was not injured. -10/20/12" [Client #2] was singing children's songs. [Client #4] got irritated and told [client #2] to shut up while using profanity and smacked [client #2] on his back." The I/A report indicated client #2 was not injured.		are carried out. 6/14/13In addition to the submitted plan, a system for identifying and determining cause/effect and preventative approaches to incidents of client-to-client aggression will be developed by 6/15/13. Client to client aggression will be reported to the administrator and BDDS as applicable. If needed, an IDT meeting will be held to discuss modifications to the milieu, behavior plans, staff assignments, additional training, or disciplinary measures, or other issues specifically relevant to the client/s. Once developed, staff will be trained on this system. The system will be monitored by the Behavioral Health Director or designee who will review incident reports involving client to client aggression to ensure system compliance. Changes will be made if necessary to the system as needed to assure the effectiveness of the methodology. 6/21/13 While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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	-10/12/12 "Both clients (clients #2 and #4) were agitated on arrival & (and) staff directed them to stay separate & calm down. [Client #4] walked over into the area & [client #2] approached him saying why you have to be like that & [client #4] went after him (client #2) and fight insued (sic). No punching more arm slapping." The I/A indicated clients #2 and #4 were not injured. -9/28/12 '[Client #4] hit [client #2] on his (R) (right) shoulder." The I/A report indicated client #4 was redirected. The I/A report indicated client #2 was not injured. The above mentioned I/A reports of client to client aggression/abuse indicated the facility did not conduct an investigation in regard to the incidents of aggression/abuse. Interview with administrative staff #1 and Service Coordinator (SC) #1 on 5/3/13 at 3:10 PM indicated clients #2 and #4 demonstrated physical aggression. Administrative staff #1 indicated most of the incidents between clients #2 and #4 occurred at the day service program. SC #1 indicated the day service program would conduct the investigations if they occurred at the day program. SC #1 indicated she (SC #1), administrative staff			

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	and/or the nurse would conduct the investigations if they occurred at the group home. Administrative staff stated they would "meet as a group afterwards to evaluate if one is an abuser or feel he is being abused." Administrative staff #1 stated "No, we did not follow our policy." 3. The facility's reportable incident reports, Incident/Accident Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's 5/24/12 I/A indicated "[Client #4] reported to staff [female client] has been touching him inappropriately on van." The 5/24/12 I/A indicated other peers who rode the van and the van driver were interviewed. The I/A did not include the names of others who were interviewed and/or the witness statements of the interviews. The I/A indicated client #4 indicated the female's touching had occurred on other occasions. The I/A indicated client #4 was encouraged to report when the incidents occurred. The I/A did not indicate any additional documentation/evidence of an investigation. Interview with administrative staff #1 on 5/3/13 at 3:10 PM stated "It does not look like an investigation was done." 4. The facility's reportable incident reports, Incident/Accident Reports and/or			

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	investigations were reviewed on 5/2/13 at 11:53 AM. The facility's 5/6/12 I/A report indicated "Staff noticed [client #4's] wrists were scabbed and scratched up on both sides. Client tried to hide it." The I/A indicated staff cleaned the areas and applied Triple Antibiotic ointment to the areas. The I/A indicated "...Cause is unknown and he is unable to tell us...." The I/A also indicated "Nurse spoke (with) client @ (at) workshop. He stated that he was scratching himself on & around his wrist...." The 5/6/12 I/A did not indicate any staff and/or clients were interviewed in regard to the 5/6/12 incident. Interview with administrative staff #1 on 5/3/13 at 3:10 PM indicated no additional information/ investigation was documented on the I/A. 5. The facility's reportable incident reports, Incident/Accident Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's reportable incident reports, the Incident/Accident Reports and/or investigations indicated the following: -6/6/12 "[Client #4] was upset with [client #5] over pulling a chair & he (client #4) hit [client #5]." The I/A report indicated client #5 was not injured.			

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	-9/28/12 "During lunch, [client #4] became upset because [client #5] walked behind [client #4's] chair on his way to throw his trash away, and [client #4] stood up and hit [client #5] two times, once in his left shoulder, and once on his chest (sic)." The I/A indicated client #5 was not injured. The 6/6/12 and 9/28/12 I/As did not indicate the facility conducted an investigation in regard to the client to client abuse/aggression incidents. Interview with administrative staff #1 on 5/3/13 at 3:10 PM indicated no investigation was conducted in regard to the above mentioned client to client incidents. 6. A facility owned day program observation was conducted on 5/3/13 from 10:00 A.M. until 11:05 A.M. At 10:10 A.M., client #5 was seated at a work table. Client #2 walked to the work table and stated, to this surveyor "Did you hear what I did? I pulled out a pocket knife, and showed it." Client #2 then pointed to client #5 and began saying "He thinks he's tough, he don't know how to fight, he ain't tough." Client #5 then said "Yeah, he pulled out a knife, he's weak, he ain't tough."			

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	A review of the facility's records was conducted at the facility's administrative office on 5/3/13 at 12:05 P.M. Review of the facility's internal Incident/Accident reports indicated the following: -Incident report dated 5/1/13: "The clients told me that the bus driver wanted to talk to staff. He said that [client #2] had pulled out a 2 inch knife during the trip he told the driver he 'maybe' won't do it again. [Client #2] came outside to the van and was smiling and looking proud of himself, claiming he didn't do anything. When staff asked him for the knife, he stated it was his, he didn't steal it and didn't want it to be taken away...The SC (Service Coordinator) was called, she instructed to ask him for the knife and leave him alone otherwise. He was willing to bargain for it by midafternoon (keep it at home, don't take it to workshop) but didn't give it to staff till late in the evening. He wrapped it heavily in paper and tape and wrote his name. Staff unwrapped it to verify it really was a knife. It was a folding knife with a 2 inch blade and serrated edge. It looks easily concealable." No documentation was submitted to indicate the facility immediately reported the incident to the administrator and other officials. An interview with the Service (SC) was			

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	conducted at the facility's administrative office on 5/3/13 at 12:15 P.M. The SC indicated there was no written documentation available for review to indicate a thorough investigation was conducted in regard to this incident. When asked if an investigation had been conducted the SC stated "I didn't know we had to do an investigation." When asked if the van driver, [client #5] or any other clients on the van were interviewed, the SC stated, "No. I didn't think we could interview the other clients and I didn't interview [client #5]." No documentation was submitted to indicate a thorough investigation had been conducted. 9-3-2(a)			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 5 of 13 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to put corrective measures in place in regard to the identified patterns of aggression for clients #2 and #4. Findings include: The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following: -1/11/13 [Client #4] began yelling at [client #2] saying that [client #2] could not tell him what to do. [Client #2] then pushed [client #4] which made [client #4] fall backwards onto his buttocks." The I/A indicated client #4 was not injured. The I/A indicated "...Bx (behavior) Plan in place to address aggression. Plan appears to overall be effective incidents within normal range...." -10/21/12 "[Client #2] was talking with client. [Client #4] said 'shut up' to [client	W000157	An IDT meeting was held to investigate the incidents regarding to clients #2 and #4 5/13/13. No abuse, neglect or exploitation was suspected during these incidents. Client # 5 will have an IDT by 6/10/13 to rule out abuse, neglect or exploitation modifications to his plan and recommendations will follow this meeting. Corrective actions of the Behavior Plans for clients #2 and #4 have been revised to indicate that both clients are to be monitored for the remainder of the day following any aggression. An IDT meeting will occur within 24 hours of any episode of client on client aggression to determine if abuse, neglect, or exploitation occurred. Protective measures will be put into place to ensure the safety of all clients following aggression. To ensure future compliance, posters explaining client rights and reporting requirements were distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally all staff will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation at least annually unless changes occur or need requires this to be done more frequently. To ensure	06/10/2013

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	#2]. [Client #2] then hit him (client #4) and started yelling. Staff separated, redirected and told him that is not appropriate." The 10/12/12 I/A indicated client #4 was not injured. The I/A report indicated the clients were separated and "...monitored for further aggression. None occurred. Behavior plans followed...." -10/20/12 "[Client #2] was singing children's songs. [Client #4] got irritated and told [client #2] to shut up while using profanity and smacked [client #2] on his back." The I/A report indicated client #2 was not injured. The 10/20/12 I/A indicated the clients were separated and monitored for further aggression. The I/A report indicated "Behavior Plans followed." -10/12/12 "Both clients (clients #2 and #4) were agitated on arrival & (and) staff directed them to stay separate & calm down. [Client #4] walked over into the area & [client #2] approached him saying why you have to be like that & [client #4] went after him (client #2) and fight insued (sic). No punching more arm slapping." The I/A indicated clients #2 and #4 were not injured. The I/A report indicated client #2 and #4's behavior plans addressed aggression.		that Service Coordinators are trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin, the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for abuse, neglect (including the neglect of medical care), exploitation and injuries of unknown origin prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral Health Director will review progress notes regularly. To ensure future compliance, The Service Coordinator will visit the clients once a week at home and once a week at the day services program for two months to ensure behavior plans are followed and recommendations put in place are carried out. 6/14/13In addition	

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	-9/28/12 "[Client #4] hit [client #2] on his (R) (right) shoulder." The I/A report indicated client #4 was redirected. The I/A report indicated client #2 was not injured. The above mentioned I/A reports indicated the facility failed to put corrective measures in place which address the targeted incidents of aggression between the clients. Interview with administrative staff #1 and Service Coordinator (SC) #1 on 5/3/13 at 3:10 PM indicated clients #2 and #4 demonstrated physical aggression. Administrative staff #1 indicated most of the incidents between clients #2 and #4 occurred at the day service program. SC #1 indicated the day service program would conduct the investigations if they occurred at the day program. SC #1 indicated she (SC #1), administrative staff and/or the nurse would conduct the investigations if they occurred at the group home. Administrative staff stated they would "meet as a group afterwards to evaluate if one is an abuser or feel he is being abused." Administrative staff #1 stated "No, we did not follow our policy." SC #1 indicated the clients' IDTs did not meet to address the identified pattern of aggression between the two clients.		to the submitted plan, a system for identifying and determining cause/effect and preventative approaches to incidents of client-to-client aggression will be developed by 6/15/13. Client to client aggression will be reported to the administrator and BDDS as applicable. If needed, an IDT meeting will be held to discuss modifications to the milieu, behavior plans, staff assignments, additional training, or disciplinary measures, or other issues specifically relevant to the client/s. Once developed, staff will be trained on this system. The system will be monitored by the Behavioral Health Director or designee who will review incident reports involving client to client aggression to ensure system compliance. Changes will be made if necessary to the system as needed to assure the effectiveness of the methodology. 6/21/13 While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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	15G116	A. BUILDING 00 B. WING	05/16/2013

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	9-3-2(a)			

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W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 sampled clients (#2), the client's Individual Support Plan (ISP) and/or behavior plan failed to specifically indicate how facility staff were to monitor the client to prevent elopement from the day program. Findings include: The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 5/2/13 at 11:53 AM. The facility's 3/12/13 reportable incident report indicated "Staff informed workshop manager at 12:20 pm that she could not find [client #2]. Staff paged [client #2] to the front office and had all staff search their areas within the building. Staff along with workshop manager left in their vehicles to search the neighborhood while center staff continued to look on site. Emergency services were called @ (at) 12:43 and arrived @ 12:55 to obtain a picture stating they would return. After speaking with emergency services, Facility Manager joined in a vehicle search. Staff in vehicles kept in contact via cell phones along with maintaining	W000240	This client's Behavior Plan has been updated to reflect monitoring procedures to prevent elopement, specific definitions of the physical techniques have also been added. The plan previously stated that this client was not to be left alone while upset. Day Services staff will be retrained to provide proper supervision to monitor this client by 6/15/13. To ensure future compliance, the service coordinator will collect data from the various sites of service and will summarize it on a monthly basis. The Behavioral Health Director will audit these summaries monthly until proficiency has been established and then will fade to periodic audits. Adjustments will be made and training will take place where necessary.6/14/13The service coordinator will observe client and staff at the day program and home on a weekly basis to ensure that preventative measures are being implements on a regular basis. Once proficiency in implementation of the plan is established monitoring visits will reduce to two times per month. 6/21/13 While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of	06/15/2013

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	contact with center., At 1:23 pm, Facility Manager stated she had a visual on [client #2] and was at the Jeffery Group home in Lowell. She asked [client #2] if he wanted to come back in her vehicle to return to the center. [Client #2] took off a second time and entered the [name of restaurant] stating he wanted to go to the restroom when he came out he immediately went out the side door and headed East again. The [name of town] emergency made contact with surrounding communities and @ 1:30 the County sheriff and (sic) arrived to assist the Facility Manager. After emergency personnel spoke with [client #2] he willingly got in her vehicle and was transported back to the center...." The facility's 3/12/13 reportable incident report indicated "...2. [Client #2's] work area will be maintained directly in front of staff working area. 3. During lunchtime [client #2] will be asked to sit at the front of the cafeteria which would be closer in proximity of the front office and kitchen area...." The 3/18/13 follow-up report indicated the day service program met to put in place corrective actions. The follow-up report indicated "Staff will continue to monitor [client #2]." A facility owned day program observation was conducted on 5/3/13 from 10:00 A.M. until 11:10 A.M. During		proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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	the entire observation period, client #2 walked in and out of the workshop area unsupervised. At 11:00 A.M., day program DSP (Direct Support Professional) #5 walked over to DSP #6 and asked "Where is [client #2]?" Both staff looked around trying to find client #2 who was standing at the back of the workshop looking at books in a box. Client #2's record was reviewed on 5/2/13 at 3:39 PM. Client #2's 3/13 Behavior Plan indicated client #2 had a history of elopement. Client #2's 3/13 behavior plan indicated client #2 had eloped from the group home 2 days in a row in January 2013. The behavior plan also indicated elopement was defined as "[Client #2] will try to escape from a situation where he feels teased or threatened...." Client #2's 3/13 behavior plan failed to specifically indicate how facility staff were to monitor the client at the group home and/or at the day program to prevent client #2 from eloping. Interview with Service Coordinator (SC) #1 on 5/3/13 at 3:10 PM stated client #2 "will elope when upset or told something he does not like." When asked how client #2 was monitored to prevent elopements, SC #1 stated "He has proactive measures in his plan."			

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 3 sampled clients (#1) and for 2 additional clients (#4 and #5), the facility failed to implement the clients' program plan objectives when opportunities for training existed. Findings include: An evening observation was conducted at the group home on 5/1/13 from 5:30 P.M. until 7:00 P.M. From 6:00 P.M. until 7:00 P.M., clients #1, #4 and #5 sat in the living room with no meaningful activity. Direct Support Professional (DSP) #1 would check on the clients but did not offer any meaningful activity. DSP #2 stayed in the office/bedroom doing inventory and did not offer any meaningful activity to clients #1, #4 and #5. A review of client #1's record was conducted on 5/3/13 at 4:15 P.M. The Individual Support Plan (ISP) dated 3/6/13 indicated the following objectives	W000249	All staff will be retrained on implementing the client's IPP, providing active treatment and the importance of community activities on an ongoing basis by 6/15/13. To ensure future compliance, The Service Coordinator will visit the home once a week for 2 months and bimonthly thereafter to ensure that active treatment is taking place. The Service Coordinator will also review client activity logs to ensure the clients are all being taken out into the community. 6/14/13The service coordinator will collect data from the day program and residential location weekly for 4 weeks and then will fade to monthly once proficiency has been established. The Coordinator will summarize the data and analyze the summary at least monthly to ensure continued growth in goal areas. 6/21/13 While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training,	06/15/2013

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	which could have been implemented during the 5/1/13 observation period: "Will learn to select amount to subtract for budget planning...Will write/recite his correct and current telephone number and the city he lives in...Given a random sampling of time settings, will tell time correctly." A review of client #4's record was conducted on 5/3/13 at 3:45 P.M. A review of client #4's ISP dated 3/5/13 indicated the following objectives which could have been implemented during the 5/1/13 observation period: "Will walk 5 days a week for 15 minutes...Will continue to record entry on his budget sheet for funds that are received or spent twice a week...Will learn to fold his clothes when laundry is complete...Will learn to zip and button...." A review of client #5's record was conducted on 5/3/13 at 3:15 P.M. A review of client #5's ISP dated 3/6/13 indicated the following objectives which could have been implemented during the 5/1/13 observation period: "Will wear his glasses 1 hour a day at home...Will continue to improve his communication through utilizing team building skills...Will continue to improve his money management skills by learning to work on balancing his budget and writing		community outings, and appropriate disposable of sharps.	

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	items on budget sheet with amount." The Service Coordinator (SC) was interviewed on 5/9/13 at 1:25 P.M. The SC indicated active treatment should be ongoing and training objectives should be implemented at all times of opportunity. 9-3-4(a)			

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W000289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 3 sampled clients (#2) and for 1 additional client (#4), the facility failed to specify the type of restraints/behavioral interventions which could be utilized with each client. Findings include: Client #2's record was reviewed on 5/2/13 at 3:39 PM. Client #2's 3/13 Behavior Plan (B/P) indicated client #2 demonstrated physical aggression which was defined as "[Client #2] will throw objects when angry with the potential of hitting others, or striking other with an open or closed hand." Client #2's 3/13 behavior plan indicated client #2 should be separated from others when he became aggressive. The behavior plan indicated staff was to tell client #2 "...his actions are inappropriate and that talking is a much more effective way of dealing with her (sic) problems...." The plan also indicated facility staff were to encourage the client to participate in deep breathing relaxation exercises. The plan indicated	W000289	This client's Behavior Plan has been updated to reflect monitoring procedures to prevent elopement, specific definitions of the physical techniques have also been added. The plan previously stated that this client was not to be left alone while upset. Day Services staff will be retrained to provide proper supervision to monitor this client by 6/15/13. To ensure future compliance, the service coordinator will collect data from the various sites of service and will summarize it on a monthly basis. The Behavioral Health Director will audit these summaries monthly until proficiency has been established and then will fade to periodic audits. Adjustments will be made and training will take place where necessary. The service coordinator will observe client and staff at the day program and home on a weekly basis to ensure that preventative measures are being implements on a regular basis. Once proficiency in implementation of the plan is established monitoring visits will reduce to two times per month. 6/21/13 While present, Service	06/15/2013

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	"...If physical aggression continues utilize the least restrictive NICE (Non-Violent Intervention for Crisis and Empowerment) techniques necessary to ensure the safety of [client #2] and others...." Client #2's 3/13 BP did not indicate the specific techniques the staff could use with client #2 when he was physically aggressive. Client #4's record was reviewed on 5/3/13 at 2:25 PM. Client #4's 3/13 Positive Behavioral Supports indicated client #4 demonstrated verbal aggression defined as "includes but not limited to verbal threats, to staff or peers involving any kind of harm, the use of derogatory terminology and increased volume of speech or yelling." The 3/13 behavior plan also indicated client #4 demonstrated physical aggression defined as "includes but not limited to hitting, kicking, grabbing, shoving or the use of an object as a weapon to attempt to intentionally cause harm to others." Client #4's behavior plan indicated others should be removed from the area when client #4 demonstrated physical aggression. The plan indicated staff was to tell client #4 "...his actions are inappropriate and that talking is a much more effective way of dealing with her (sic) problems...." The plan also indicated facility staff were to encourage the client to participate in deep breathing		Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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	relaxation exercises. The plan indicated "...If physical aggression continues utilize the least restrictive MANDT (physical intervention techniques) techniques necessary to ensure [client #4's] safety and the safety of others...." Client #4's 3/13 behavior plan did not indicate the specific techniques the staff could use with client #4 when he was physically aggressive. Interview with administrative staff #1 and Service Coordinator (SC) #1 on 5/3/13 at 3:10 PM indicated they were not aware the clients' behavior plans needed to include the specific techniques staff could use with the clients. 9-3-5(a)			

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W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to assure the repair of adaptive equipment for 1 of 3 sampled clients who was prescribed eyeglasses and who used a communication device (client #3). Findings include: An evening observation was conducted at the group home on 5/1/13 from 5:30 P.M. until 7:00 P.M. During the observation period client #3 was unable to articulate his speech clearly. Client #3 was not observed utilizing a communication device. During the entire observation period client #3 did not and was not prompted to wear eyeglasses. A review of client #3's record was conducted at the facility's administrative office on 5/3/13 at 3:00 P.M. Review of client #3's record indicated a most current vision exam dated 7/31/12 which indicated he was prescribed eyeglasses. The most current Individual Support Plan (ISP) dated 3/4/13 indicated: "[Client #3]	W000436	Client #3 will have a risk plan put in place in regards to his eyeglasses by 6/15/13 which will provide him with multiple prompts and documentation of these prompts throughout the day. Client #3 has regularly refused to wear his eye glasses for years and programming has proven ineffective. In addition Client #3 will have a visual assessment to identify the functionality of his vision without modification. The results of this assessment will be added to his plan. Please note Correction to Client #3 had an I POD for use for communication. Client #3's I PAD is not meant to be a communication device. Guardian has requested that client #3 not take his IPAD out of the house for any reason for fear of theft and distraction from his job or programming. This request will be obtained in writing by 6/15/13 and will be revisited annually. Client #3 IPOD had a speaker devise attached to it. Client #3 had year of training to use this devise but prefers that people get to know him and speak to him normally rather than through	06/15/2013

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	wear his eyeglasses daily (sic)...Speaking difficulties: Uses sign language, gestures, and has limited vocabulary but can speak some; has objective and uses an IPAD for communication." An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 5/9/13 at 1:25 P.M. The SC indicated staff should have prompted client #3 to wear his prescribed eyeglasses and to use his communication device. 9-3-7(a)		assistive technology. An appointment for Client #3 to see a speech pathologist will be made by 6/15/13. When evaluated an alternative method of communication will be built into his plan. He has clearly chosen to not use the I POD as a communication device.	

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W000454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility failed to ensure the client and the staff followed sanitary guidelines when administering insulin. The facility failed to ensure sharps were disposed of properly/safely. Findings include: During the 5/2/13 observation period between 5:40 AM and 8:00 AM, at the group home, client #1 checked his own blood glucose level. Once the client was done, the client stretched his arm back behind him and dropped a lancet (sharp for blood draw for Glucometer/glucose monitor) into a grayish blue container with a clear lid located behind a trash can in the office area. Client #1 did not use and/or staff #5 did not encourage the client to sanitize his finger with an alcohol swab prior to sticking the client's finger with the needle. The container was open in the middle (exposed sharps) and 6 individual sharps were located on the outside of the container. Also, during the 5/2/13 observation period, staff #5 administered client #1's morning medications. As staff #1 was preparing to	W000454	a new labeled sharps container was provided to the home on 5/3/13. The Service Coordinator will ensure that the sharps container is being used during weekly house visits for 2 months and bimonthly thereafter. The Service Coordinator will also review incident reports which are to be used to identify missing adaptive equipment. The work instruction of insulin injections will be revised by 6/15/13 all staff will be trained on this plan by 6/15/13. This training will include modeling and return demonstration. Nurses in conjunction with the Service Coordinator will observe staff administering subcutaneous medication to ensure it is done in a sanitary manner initially and then weekly for week for 2 months and bimonthly thereafter to ensure proficiency. The Community Services Nurse will also review all incident reports for the home which document medication errors. 6/14/13The service coordinator will ensure that the sharps container is being used during weekly house visits for 2 months and bimonthly thereafter. The Service Coordinator in conjunction with the community service nurse will also review requests from the	06/15/2013

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	15G116	A. BUILDING _____ B. WING 00	05/16/2013

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	administer client #1's insulin, staff #1 removed the lid from the insulin vial, placed a needle into the vial and drew out insulin into the needle. Staff #5 then administered the shot/insulin into the back of client #1's arm. Staff #5 did not use an alcohol swab to clean the insulin lid and/or use an alcohol swab to sanitize client #1's arm/area of arm prior to administering the insulin. Staff #5 did not wash his hands at any time prior and/or after the procedure. Staff #5 did put gloves on prior to administering the insulin. The facility's undated Step by Step Procedure Administration of Insulin was reviewed on 5/2/13 at 1:45 PM. The insulin policy indicated facility staff were to gather supplies needed (insulin bottle, syringe, alcohol swabs, gloves and sharps container). The undated policy indicated the following: "...3 Wash your hands... 5. Remove the lid from the insulin bottle to make sure it hasn't expired. Also check for the Name, Medication ordered, Dosage, Route of Administration and Time ordered. 6. Wipe the rubber top of the bottle with an alcohol swab... 12. The most common places to inject insulin are the abdomen, the back of the		home to ensure that medical supplies like a sharps container are consistently available. 6/21/13While present, Service Coordinators and Managers will also monitor for client-to-client aggression, implementation of proactive and reactive measures of the behavior plan, providing active treatment, goal training, community outings, and appropriate disposable of sharps.	

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	upper arms, the upper buttocks and the outer thighs. Choose one of these areas to inject the insulin and wipe the skin with an alcohol swab.... 17. Throw away the alcohol swab and gloves. 18. Wash your hands...." Interview with LPN #1 on 5/3/13 at 3:50 PM indicated any sharps should be disposed of in a sharps' container. LPN #1 indicated there should be a sharps' container in the home. LPN #1 indicated alcohol swabs should be used to clean and sanitize the finger and the skin prior to doing the blood glucose test and prior to administering client #1's insulin. LPN #1 indicated the insulin vial lid should also be wiped with an alcohol swab. Interview with administrative staff #1 on 5/2/13 at 4:10 PM indicated the sharps' containers were red and there was one in each group home. Administrative staff #1 indicated the containers the facility purchased/used had an opening large enough for a human hand. Administrative staff #1 indicated the Service Coordinator went to the group home and was not able to locate the container the surveyor had described behind the trash can. Administrative staff #1 indicated sharps should be in an appropriate container and not laying around/on the container.			

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	9-3-7(a)			

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W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 3 sampled clients (client #1), the facility failed to assure the staff provided food in accordance with the client's diet order. Findings include: An evening observation was conducted at the group home on 5/1/13 from 5:30 P.M. until 7:00 P.M. At 5:55 P.M., client #1 served himself unmeasured amounts of food, which consisted of chicken, whole kernel corn, corn bread and sliced bread. A review of client #1's record was conducted on 5/3/13 at 4:15 P.M. Review of client #1's most current Physician's Order dated 5/2013 indicated: "1800 Calorie Diet." Review of client #1's Individual Support Plan (ISP) dated 3/6/13 indicated: "Individual's Diagnosis: Diabetes Mellitus." A review of the facility's 5/1/13 posted menu on 5/1/13 at 6:15 PM, indicated client #1 was to receive chicken, corn, cornbread and sliced bread. The 5/1/13 menu did not indicate the specific serving amounts.	W000460	Nursing staff will have trained staff on the diabetic diets by 6/15/13. In order to prevent reoccurrence the Nurse in conjunction with the Service Coordinator will train both home and day program on the diabetic diet plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks including modeling and return demonstrations of appropriate exchanges. A set of measured serving utensils will be obtained for this home and Client # 1 will be trained on utilizing them as he prefers to cook for and serve himself. Observations will include meal time, medication administration, and documentation review of the MAR, and blood sugar readings. In addition the Area Manager will audit the home on a monthly basis to ensure the serving utensils are still available. 6/14/13To ensure future compliance, The Service Coordinator will visit the home once a week for 2 months and bimonthly thereafter to ensure that the diabetic diet plan is being followed, the medication administration record is accurate, and blood sugar readings are documented and within the	06/15/2013

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	An interview with the Service Coordinator (SC) was conducted on 5/9/13 at 1:25 P.M. The SC indicated staff should have followed the client's prescribed diet. 9-3-8(a)		parameters established in the individuals risk plan, as well as active treatment taking place. The Service Coordinator will also review client activity logs to ensure the clients are all being taken out into the community. 6/21/13 Professional staff will be on site to monitor each meal, including weekends, until each staff have shown proficiency in prompting the client to follow his diabetic diet. Proficiency means staff are successful when monitored without need for direction three consecutive times. This monitoring system will continue as long as is necessary until it meets the proficiency level. Once staff has shown that they are proficient in diet management of the diabetic client, including the use of measured serving utensils, monitoring will fade to three times a week, and then weekly x 4weeks and two time per month ongoing.	